VISION SERVICE PLAN

ENROLLMENT FORM

Vincennes University

Group Number: 12183445

Employee Name:_____
Last name, first name, middle initial

Employee Social Security Number:_____

Employee Address:_____

Employee Date of Birth:_____

Effective Date of Coverage:_____

_____ Employee Only

_____Employee plus one (spouse OR one child)

_____Employee and Children

_____Employee and Family

_____Terminate coverage(Coverage will term at end of December)

_____
Employee signature/date